



PT ID: _____

PCP: _____

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

5 Year Old Parent Observations

Are there any concerns you would like to discuss today? _____

Activities/Interests:

List any extracurricular activities (i.e. a sport, dance): _____

List any interests (i.e. instrument, art, playing outside): _____

How much screen time (TV/tablet/phone/etc) does your child have per day? _____

Diet/Sleep:

Does your child eat well? (i.e. has consistent appetite, not too picky)YES NO

• What does your child drink? _____

• If picky, what does your child dislike? _____

Any concerns about voiding or stooling? (i.e. constipation, bedwetting)YES NO

Is your child potty trained: (check all that apply) Day Night Urine Stool

Does your child have any problems with sleep? YES NO

Development:

Do you have any concerns about your child's hearing or vision? YES NO

Any concerns about your child's development? YES NO

Does your child: (check all that apply)

draw a square

use complete sentences

know first/last name

write name

use tenses or pronouns

count to 10

catch a ball

speak 100% understandably

follow rules

Social/Behavior:

Has your child attended preschool? YES NO If yes, did he or she like it/do well? YES NO

Are there any family or social issues you would like to discuss?YES NO

Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? YES NO

Safety/Preventative Health:

Does your child use a car seat or booster 100% of the time? YES NO

Is your home/car a smoke-free environment? YES NO

Are you brushing your child's teeth with fluoride toothpaste? YES NO

Has your child seen a dentist in the last 6 months? YES NO

Does your child participate in regular physical activity? (about 1hr play/sport) YES NO

Does your child always wear a helmet when riding bike/scooter/skiing/etc? YES NO

Have you discussed "stranger danger" with your child? YES NO

Have you discussed trampoline/water safety with your child? YES NO

Do you own a gun? YES NO If yes, is it stored safely (i.e. locked case)? YES NO

Are your child's immunization up to date? YES NO

Does your child have any allergies (that you know of)? YES NO

Please list any medications or supplements your child took this week: _____